tal health difficulties among victims of bullying. Animal models may provide useful insights, because they allow for a better control of the bullying experience and offer an opportunity to explore biological mechanisms in more depth. For example, an experiment on mice demonstrated the role of brain-derived neurotrophic factor in the mesolimbic dopamine pathway to explain social aversion among mice exposed to repeated aggression[10].

Tackling bullying behaviors could not only reduce children's and adolescents' mental health symptoms but also prevent psychiatric and socio-economic difficulties in adulthood. Anti-bullying programs show promise in controlling bullying behaviors[11]. However, the chances of eradicating bullying completely are minimal and we need to acknowledge that, despite such programs, a considerable proportion of young people will not escape this form of abuse. Intervention efforts should therefore also focus on limiting distress among young victims and possibly, by the same token, preventing long-lasting difficulties in later life. A new innovative strategy could aim at preventing children from becoming the targets of bullying in the first place. Such a public health approach might be a more effective way to reduce the bullying-related burden.

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Suicide risk assessment: tools and challenges

The World Health Organization estimates that over 800,000 people die by suicide each year, and for each suicide as many as 20 more individuals have attempted suicide[1]. The assessment and management of suicide risk is considered a core competency for psychiatrists, yet guidelines diverge in their recommendations and there is no universally accepted model. Risk assessment and management is best conceptualized as a process – not a single event – that includes structured evaluation, intervention, and re-assessment. Here, we comment on benefits of risk assessment, tool selection, risk assessment in self-injurious patients, and the unique challenge of working with patients who harbor thoughts of suicide that they do not disclose.

Some psychiatrists are reluctant to use risk assessment suicide tools, worrying that risk stratification is too inaccurate to be useful; that suicide-specific treatments, including medications and psychotherapies, are unavailable or do not improve outcomes; or that an over-emphasis on risk management might lead to defensive medicine. Although tools are imperfect, most experts agree that a structured assessment, meaning a consistent way of assessing and integrating risk and protective factors, is more likely to elicit relevant patient information and produce consistent risk formulations. Additionally, several evidence-based suicide-specific treatments exist, including commonly available medications, increasingly available psychotherapies, and relatively simple multidisciplinary interventions[2]. While uncertainty about a patient's suicide risk might lead to conservative recommendations, using and documenting a risk assessment process that educates patients about their risk, while prioritizing autonomy and outpatient treatment, should result in the most appropriate individualized care, effective communication with other providers, and medico-legal protection.

A growing literature supports this assertion. The Collaborative Assessment and Management of Suicidality (CAMS) model is a prototype clinical framework organized around the cooperative completion of the quantitative and qualitative Suicide Status Form (SSF). This model, which encourages problem-solving to reduce the suicide "drivers" and boost coping, is designed to enhance the patient-clinician alliance, build motivation, and avoid inpatient hospitalization. Completion of the initial SSF identifies suicide drivers, and the abbreviated follow-up form tracks improvement[3]. Drawing on CAMS, military-sponsored researchers developed a more complete and flexible approach, the Therapeutic Risk Management (TRM) framework. In this framework, clinicians augment evaluation with a risk assessment tool of their choosing, to stratify risk in terms of severity (low, medium, or high) and temporality (acute or chronic), and to collaboratively develop a safety plan based on a six step template[4]. The CAMS and TRM models share a clinically-motivated emphasis on avoiding involuntary hospitalization, arguing that it can damage the alliance and result in psychosocial setbacks that might exacerbate long-term suicide risk.

For psychiatrists not trained in CAMS, we recommend the TRM framework, including use of an assessment tool. When selecting a tool, consider whether it has been validated, has a quantitative component, can be repeated, is not diagnosis-specific, is available in a variety of formats, and is available in relevant languages. In our view, the Beck Scale for Suicide

Ideation (SSI)[5] and the Columbia-Suicide Severity Rating Scale (C-SSRS)[6] are good options.

The SSI is a 19 item clinician-administered scale querying, among other things, the patient's wish to die, wish to live, and the duration and intensity of thoughts of suicide. Each item is rated on a 3-point scale from 0 to 2, with a total score ranging from 0 to 38. Cutoffs and odds ratios for suicidal behaviors have been established for various populations[5], and the scale has been validated in multiple languages. The SSI can be administered at initial evaluation and subsequently repeated to assess improvement.

Similarly, the C-SSRS characterizes current thoughts of suicide and past suicidal behaviors. It features a clinician-administered initial evaluation form, a "since last visit" version, and a self-report form. Studies have shown the C-SSRS to be sensitive, specific, and reflective of changes in patients' conditions[6]. The C-SSRS has also been translated into and validated in several languages.

Many patients, particularly adolescents and those with borderline personality disorder, suffer from non-suicidal self-injury and/or low-lethality suicidal behavior. Historically, clinicians have viewed non-suicidal self-injury as distinct from suicidal behavior and/or dismissed low-lethality suicide attempts as "suicidal gestures". Some are concerned that repeated safety assessments reinforce these behaviors or are disproportionate to the patients' suicide risk. However, self-injuring patients are, in fact, at high risk of death by suicide, and the risk is even higher among patients who experience multiple episodes of self-injury and among patients who report suicidal intent, regardless of lethality[7]. Additionally, consistent attention to and an agreed-upon strategy for managing suicidal crises has been identified as a common factor among five evidence-based treatments for borderline personality disorder[8]. Thus, we recommend taking both self-injury and low-lethality suicidal behavior seriously, by educating these patients about their elevated risk, diagnosing personality disorders when present, and offering a safety-focused treatment.

Some suicidal patients deny having suicidal thoughts. This might be a conscious attempt to avoid hospitalization or speed discharge, or an unconscious defense against suicidal impulses. Some patients suffer transient but intense suicidal thoughts, which are not captured at the time of assessment. In any case, the obligation to engage and treat patients who feel they do not need or want help is a special challenge in psychiatric medicine. New research suggests that objective measures of patients' cognitive processes might provide insight into their suicide risk. Specifically, the "death/suicide implicit association test", which asks patients to categorize words associated with life and suicide as fast as they can, has been shown in a prospective study to predict suicidal behavior among veterans over and above other known risk factors[9]. Researchers are also beginning to subtype suicidal behavior and to explore the potentially distinct mechanism of impulsive suicide attempts[10].

Although more research is needed to improve assessment and prevention of suicidal behavior, there have been undeniable advances in our ability to manage suicidal patients. By combining foundational ethical and clinical concepts – such as respect for autonomy and the importance of a strong patient-clinician alliance – with a process-oriented framework and evidence-based tools and interventions, psychiatrists can reduce patient risk without excessive use of restrictive and expensive treatment settings.

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